

## **Medical Assistance Administration**



# **Ground and Air Ambulance Medical Transportation**

## **Billing Instructions**

**July 2000**

## **About this publication**

This billing instruction is designed to help ambulance providers and their staff understand Medical Assistance Administration (MAA) regulations and requirements necessary for reporting accurate and complete claim information.

**This publication supersedes all previous MAA Ground/Air Ambulance Medical Transportation Billing Instructions.**

Published by the Medical Assistance Administration  
Washington State Department of Social and Health Services  
July 2000

**Received too many billing instructions?**

**Too few?**

**Address incorrect?**

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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# Important Contacts

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A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

## **How do I apply for a provider #?**

**Call:**

Provider Enrollment Unit  
(800) 562-6188 and  
Select Option #1

**or call one of the following numbers:**

(360) 725-1033  
(360) 725-1026  
(360) 725-1032

## **Where do I send my claims?**

**Hard Copy Claims:**

Division of Program Support  
PO Box 9247  
Olympia WA 98507-9247

**Magnetic Tapes/Floppy Disks:**

Division of Program Support  
Claims Control  
PO Box 45560  
Olympia, WA 98504-5560

## **How do I obtain copies of billing instructions or numbered memoranda?**

Check out our web site at:  
<http://maa.dshs.wa.gov>

**Or write/call:**

Provider Relations Unit  
PO Box 45562  
Olympia WA 98504-5562  
(800) 562-6188

## **Who do I contact if I have questions regarding...**

**Payments, denials, general questions regarding claims processing, or Healthy Options?**

Provider Relations Unit (PRU)  
(800) 562-6188

**Private insurance or third party liability, other than Healthy Options?**

**Write/call:**

Division of Client Support  
Coordination of Benefits Section  
PO Box 45565  
Olympia, WA 98504-5565  
(800) 562-6136

**Electronic Billing?**

**Write/call:**

Electronic Billing Unit  
PO Box 45511  
Olympia, WA 98504-5511  
(360) 725-1267

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# Definitions

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**This section defines terms and acronyms used within these billing instructions.**

**Advanced life support (ALS)** - Invasive emergency medical services requiring advanced medical treatment skills as defined by chapter 18.71 RCW. [RCW 18.73.030(18)]

**Air ambulance** – A fixed-wing or rotary aircraft that has been inspected and licensed by the Department of Health as an ambulance.

**Ambulance** - A ground or air vehicle designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation. [RCW 18.73.030(4)]

**Ambulance operator** – A person who owns one or more ambulances and operates them as a private business. [RCW 18.73.030(7)]

**“Approved Medical Program Director”** - A person who is:

- Licensed to practice medicine and surgery pursuant to chapter 18.71 RCW or osteopathic medicine and surgery pursuant to chapter 18.57 RCW;
- Qualified and knowledgeable in the administration and management of emergency care and services; and
- So certified by the department of health for a county, group of counties, or cities with populations over four hundred thousand in coordination with the recommendations of the local medical community and local emergency medical services and trauma care council. [Refer to RCW 18.71.205(4).]

**Base rate** - The department’s minimum allowable amount per transport, which includes allowances for emergency medical services provided, attendants, reusable supplies and equipment, hardware, stretchers, some disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage and specified disposable supplies.

**Basic life support (BLS)** - Noninvasive emergency medical services requiring basic medical treatment skills as defined in chapter 18.73 RCW. [RCW 18.73.030(17)]

**By Report (BR)** – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA’s published fee schedules. MAA may request the provider to submit a “report” describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. (WAC 388-531-0050)

**Categorically Needy (CNP)** - CNP programs are the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for:

- CNP only;
- Cash benefits under the SSI (Supplemental Security Income);
- TANF (Temporary Assistance for Needy Families);
- General Assistance – X (special); or
- General Assistance (children's).

CNP includes full scope coverage for pregnant women and children.

**Chart** – A summary of medical records on the individual patient.

**Client** - An applicant for, or recipient of, DSHS medical care programs.

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office (CSO)** - An office of the department which administers social and health services at the community level.

**Core Provider Agreement** - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation with MAA.

**Department** - The state Department of Social and Health Services.

**Destination/Nearest Appropriate Facility** – An institution generally equipped to provide the needed hospital or skilled nursing facility care for the injury, illness, symptom, or complaint involved. In the case of a hospital, a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition.

**Emergency** – A service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency medical service** - Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.  
[RCW 18.73.030(11)]

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Ground ambulance** - A ground vehicle designed and primarily used to transport the ill and/or injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

## Ground and Air Ambulance Medical Transportation

**Hospital** – A facility licensed under chapter 70.41 RCW, or comparable health care facility operated by the federal government or located and licensed in another state.

**Interfacility transport** – Medical transportation of a patient between recognized medical treatment facilities, requested by a licensed health care provider.

**Involuntary Treatment Act (ITA)** – See chapter 71.05 RCW and chapter 275-55 WAC for adults. See chapter 71.34 RCW and chapter 275-54 WAC for juveniles.

**Liftoff fee** - The base rate paid an air ambulance provider for transporting a client.

**Loaded Mileage** – Mileage in which a client is on board an ambulance.

**Managed Care** – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

**Maximum Allowable** - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**Medicaid** - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration (MAA)** - The administration within the department of social and health services authorized to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical

services for persons with chronic disabilities.

**Medical Control** – The medical authority on whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center (destination) assignment for the patient being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

**Medically Necessary** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

**Medicare** - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- **"Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.**
- **"Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health**

**services and supplies not covered  
under Part A of Medicare. (WAC  
388-500-0005)**

**Non-Emergency** – Any ambulance trip not meeting the criteria listed under “Emergency” in this section. This includes all scheduled runs (regardless of origin and destination) as well as transports to and from nursing facilities, physician’s clinics, and other diagnostic/treatment centers.

**Paramedic** - A person who:

- Has successfully completed an emergency medical technician course as described in chapter 18.73 RCW;
- Is trained under the supervision of an approved medical program director to:
  - ✓ Carry out all phases of advanced cardiac life support;
  - ✓ Administer drugs under written or oral authorization of an approved licensed physician;
  - ✓ Administer intravenous solutions under written or oral authorization of an approved licensed physician; and
  - ✓ Perform endotracheal airway management and other authorized aids to ventilation; and
- Has been examined and certified as a physician’s trained mobile intensive care paramedic by the University of Washington school of medicine or the department of health. See also “mobile intensive care paramedic.”

**Patient Identification Code (PIC)** - An alphanumeric code which is assigned to each Medicaid client and which consists of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tie breaker).

**Program Support, Division of (DPS)** – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Field Services;
- Managed Care Contracts;
- Provider Relations; and
- Regulatory Improvement.

**Provider or Provider of Service** - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

**Record** – Dated reports supporting claims submitted to the Washington Medical Assistance Administration (MAA) for medical services provided in a client’s home, a physician’s office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of services

must be in chronological order by the practitioner who provided the service.

**Remittance and Status Report (RA)** - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration, that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW)** - Washington State laws.

**Rotary aircraft** - A helicopter.

**Third Party** - Any entity that is or may be liable to pay all or part of the cost of medical care for a federal Medicaid or state medical care client.

**Title XIX** - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

**Trauma** – A major single- or multi-system injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

**Usual and Customary Charge** - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate for the same services normally offered to other contractors.

**Waiting time** - Time spent waiting for the client or some event or thing (e.g., ferry and

ferry crossing) necessary to complete the transport.

**Washington Administrative Code (WAC)** - Codified rules of the state of Washington.

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# About the Program

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The ambulance transportation program is part of an overall plan to provide medically necessary transportation to and from the provider of MAA covered services that is closest and most appropriate to the client's medical need. Most of the transportation MAA provides for its clients is non-emergent medical transportation. With few exceptions, non-emergent transportation is provided through a series of contracts with local transportation brokers (i.e., not by ambulance). Transportation brokers are listed on MAA's website at <http://maa.dshs.wa.gov> and in MAA's General Information Booklet.

The following types of medical transportation not provided through contracted brokers:

- Air Ambulance – emergency medical transportation by air;
- Ground Ambulance – transportation by ground ambulance that is either:
  - ✓ Emergency medical transportation; or
  - ✓ Transportation to MAA covered medical services requiring:
    - The client to be transported by stretcher or gurney<sup>1</sup>; or
    - That the client have ambulance-level medical attention available en route.

## Medical Necessity for Ambulance Transportation

Transportation that is provided by ambulance providers and billed to MAA must have the medical necessity documented in the client's file. MAA coverage of ambulance transportation is determined based on the client's condition at the time of transport. The destination must be the closest, local provider of the medically necessary MAA covered medical services.

MAA covers a client's transportation in an ambulance only if the client could not be safely (or legally) transported any other way. If a client could safely travel by car, van, taxi, or other means, the ambulance transport would not be medically necessary and the ambulance level of service would not be covered by MAA.

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<sup>1</sup> RCW 18.73.180 requires MAA to provide transportation by ground ambulance vehicle whenever the client's medical condition requires that the client be transported in the prone or supine position. Nothing prohibits ambulance providers from entering into contracts with MAA or with MAA's transportation brokers to provide non-emergent ambulance service at payment rates that are lower than typical BLS ambulance service.

State law does allow for non-emergent transportation by ground ambulance; however, this allowance applies only to clients who must be transported in the prone or supine position (for medical or safety reasons) or to clients who are likely to require medical attention en route to a diagnostic or treatment facility. Again, the client's medical condition at the time of the transport must present a valid medical or safety need and must be well documented.

A doctor's or a hospital's order for ambulance transportation is not sufficient to guarantee that MAA will pay for the ambulance transportation. The ambulance provider is responsible to ensure that the medical necessity is both valid and well documented in the client's file.

If Medicare or another third-party denies coverage of an ambulance transport on the basis of medical necessity, the provider must be prepared to demonstrate to MAA why the transport meets MAA's requirement for medical necessity. MAA's presumption in such a case is that the transport does not meet the medical necessity requirements of MAA.

## **Standards for Emergency Transport**

In Washington State, the type and mode of emergency transportation, the urgency of transport and the destination decision are determined by certified Emergency Medical Services (EMS) and trauma personnel, in conjunction with their regional "medical control." These decisions are based on their professional judgment, consultation with emergency room physicians, and industry standards. These standards are outlined in "State of Washington Pre-hospital Trauma Triage Procedures" (standards available from the Department of Health), triage plans developed and implemented by the regional EMS and trauma care councils, and client care procedures and protocols developed by the regional councils.

## **Ambulance Transports Covered in Bundled Payments**

In certain situations, ambulance transportation may be medically necessary, but it does not qualify for separate payment by MAA. This occurs when the ambulance transport is included in bundled payments to hospitals or other providers. An example of this is the transfer of the client who is a registered inpatient of a hospital to another facility for a diagnostic service (e.g., a CAT scan, etc.) and the inpatient's return trip. MAA's hospital contracts state that: "transportation services subsequent to admission and prior to discharge which are necessary to provide inpatient services under this contract are part of inpatient services." Payment for such inpatient transport is included within the hospital's Diagnosis Related Group (DRG) payment. In such a case, MAA does not reimburse the ambulance provider separately, and the ambulance provider may not bill MAA's client for the transport. The hospital is responsible for the reimbursement of the ambulance transport.

If a client is being discharged from a hospital, MAA covers and separately reimburses the medically necessary transport of the client to a qualified rehabilitation facility.

# **Levels of Ambulance Transport**

## **Ground Ambulance**

MAA reimburses for two levels of medically necessary ground ambulance transportation:

- **Basic Life Support (BLS)**

A **BLS** transport is one in which the client:

- ✓ Requires and receives basic services en route, such as control of bleeding, splinting of fracture(s), treatment for shock, and cardiopulmonary resuscitation; or
- ✓ Needs to be transported in a prone or supine position, with or without emergency services en route.

- **Advanced Life Support (ALS)**

An **ALS** transport is one in which the client requires and receives more complex services en route, such as:

- ✓ Intravenous therapy;
- ✓ Airway intubation;
- ✓ Heart defibrillation by paramedics or other ALS-qualified personnel on-board a properly-equipped vehicle; or
- ✓ Initiation of treatment for pneumothorax conditions.

An ALS transport is distinguished from a BLS transport by the kinds of medical interventions needed by the client and provided by a qualified crew. ALS involves invasive, emergency medical services requiring advanced treatment skills provided to the client en route. The level of service reimbursed by MAA depends on the medical interventions both needed and provided during the transport. MAA has documentation requirements for all ALS billings.

## **Air Ambulance**

MAA considers all air ambulance transports as ALS. Payment is based on lift-off and mileage.

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# Client Eligibility

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## Who is eligible for MAA-paid ambulance services?

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for Ground/Air Ambulance Medical Transportation services:

<u>MAID Identifier</u>	<u>Medical Program</u>
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – Children’s Health Insurance Program
CNP - Children’s Health	Categorically Needy Program – Children’s Health
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Medical Only
LCP - MNP	Limited Casualty Program - Medically Needy Program



**Please Note:** See next page for Managed Care clients.

## Limitations

Clients presenting MAID cards with the following identifiers are eligible for in-state transportation only:

<u>MAID Identifier</u>	<u>Medical Program</u>
Emergency Hospital and Ambulance Only	Medically Indigent Program
GA-U No Out of State Care	General Assistance-Unemployable
Detox Only	Detox
General Assistance – No Out of State Care	ADATSA
LCP-MNP – Emergency Medical Only	Limited Casualty Program – Medically Needy Program – Emergency Medical Only

## **Who is not eligible for MAA-paid ambulance services?**

Clients presenting MAID cards with the following identifiers are not eligible for Ground/Air Ambulance Medical Transportation services:

<b><u>MAID Identifier</u></b>	<b><u>Medical Program</u></b>
Family Planning Only	Family Planning
QMB-Medicare Only	Qualified Medicare Beneficiary-Medicare Only (MAA pays only the Medicare premiums and coinsurance costs for these clients.)

## **Can managed care clients receive Ground/Air Ambulance services?**

Clients whose MAID cards have an HMO identifier in the HMO column are enrolled in a Healthy Options managed care plan. Ground/Air Ambulance services are covered under Healthy Options managed care plans when the services are medically necessary. Services include, but are not limited to:

- Basic Life Support;
- Advanced Life Support; and
- Other required transportation costs, such as tolls and fares.

In addition, the Healthy Options plan covers ambulance services under two circumstances for non-emergencies. These circumstances are when it is necessary to transport:

- A client between facilities to receive a covered service; and
- A client, who must be carried on a stretcher or who may require medical attention en route, to receive a covered service. (RCW 18.73.180)

Please contact the Healthy Options managed care plans in your area to become familiar with their prior authorization and billing procedures. See <http://maa.dshs.wa.gov/healthyoptions> for a listing of Healthy Options managed care plans by county.

Clients covered by a Primary Care Case Manager (PCCM) need authorization from their PCCM. The PCCM's name and phone number is located in the bottom right-hand corner of the client's MAID cards.

# General Program Policies

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## General Requirements for Ambulance Providers

- Air and ground ambulances must be licensed, operated, and equipped in accordance with applicable federal, state, and local statutes, ordinances, and regulations.
- Air and ground ambulances must be staffed and operated by appropriately trained and certified personnel in accordance with applicable federal, state, and local statutes, ordinances, and regulations. Any invasive, emergency medical services required by a client during ambulance transport must be provided by properly authorized and trained personnel.
- Providers of ambulance services must provide medical justification to MAA when billing transportation claims and related services and supplies to MAA. Documentation in the client's file must include the severity and complexity of the client's condition at the time of transport.

## What is and is not included in the base rate?

- The base rate includes:
  - ✓ Emergency medical services;
  - ✓ Costs of standing orders;
  - ✓ Attendants;
  - ✓ Reusable supplies and equipment;
  - ✓ Hardware;
  - ✓ Stretchers;
  - ✓ Disposable supplies (except the two items listed below);
  - ✓ Normal waiting time; and
  - ✓ Normal overhead costs of doing business.
- The base rate does not include the following:
  - ✓ Waiting time beyond the first 30 minutes;
  - ✓ Mileage;
  - ✓ Extra attendant in specific circumstances (see page D.4);
  - ✓ Oxygen supplies and administration; and
  - ✓ Intravenous supplies and administration.

## Noncovered Ambulance Services

- MAA does not cover the following:
  - ✓ Transport determined not to be medically necessary;
  - ✓ Transport to a funeral home, mortuary, or morgue;
  - ✓ Transport by non-certified services (e.g., wheelchair vans, Ambo cabs, etc.);
  - ✓ Transport to non-appropriate facilities;
  - ✓ Transport beyond nearest appropriate facility;
  - ✓ Transport for the convenience of the client and/or family;
  - ✓ Transport in order for the client to receive treatment from a specialist or specific physician;
  - ✓ Response when clients refuse to be transported;
  - ✓ Any trip solely because the client has no other means of transportation; and
  - ✓ Ambulance transports to certain destinations:
- **Home** - Claims submitted for transports from the hospital, skilled nursing facility, nursing home, or hospice should reflect the reason(s) why the client could not have gone home by any other means without endangering his/her health.
- **Hospital to Hospital** - Example of transports that are not payable:
  - ◆ Doctor's preference (e.g., the client's primary physician practices at receiving hospital);
  - ◆ Client's preference (e.g., to be closer to home or family);
  - ◆ Evaluation and treatment of a client when inpatient status is maintained at originating hospital;
  - ◆ Back door to front door transports within the same hospital complex;
  - ◆ Insurance requirements; and
  - ◆ Special arrangements between insurance and hospital.

In general, the client must be discharged from the first hospital and the reason for the transport must be for a higher level of care not available at the originating facility.

## Ground and Air Ambulance Medical Transportation

- **24 Hour walk-in clinics, Urgent Care Centers, Free Standing Outpatient Facilities and Physician's Office** – An Emergency Department is defined as an organized hospital-based facility that is open 24 hours a day. MAA considers 24-hour walk-in clinics and Urgent Care Centers as physician-based or physician-directed clinics. Like physician offices, they are not acceptable destinations for ambulance coverage, except under the following circumstances:
  - ◆ Where stops are made at one of these entities in order to stabilize the client or because of a client's dire need for professional attention, **and immediately thereafter, the ambulance continues enroute to the hospital;** or
  - ◆ When a skilled nursing facility (SNF) or nursing home inpatient is transported roundtrip for specialized services to the nearest hospital or non-hospital treatment facility (e.g., clinic, therapy center, or physician's office) to obtain necessary diagnostic and/or therapeutic services (such as CT scan or radiation therapy) **not available** at the institution where the client is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the client is less costly than bringing the service to the client. MAA does not cover ambulance transfers to a physician's office for evaluation and management services [in the absence of any specialized services (i.e., tests or procedures that could not be brought to the client)].
- In most cases, MAA does not cover ambulance services if:
  - ✓ The trip is a routine trip to return the client home (when the client had been transported to the hospital); or
  - ✓ The client is transported from home or nursing home to the hospital outpatient department for treatment that could have been performed elsewhere (e.g. client's home or nursing home).

## **What records must be kept?**

The transportation provider must keep sufficient documentation to justify decisions about destination and type of transport for each client. The documentation must be legible, accurate, and complete. The documentation must be authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but is not limited to the following information:

- Date(s) and time of service.
- Transported client's name and date of birth.
- Name and title of person performing services.
- Medical justification for each transport (e.g., suspected heart attack)
- Pertinent medical history.
- Pertinent findings on examination (e.g., will require medical attention en route)
- All medications and/or equipment/supplies provided.
- Description of treatment/medical intervention(s) (when applicable)
- Specific location of pick-up and destination and any additional or non-scheduled destinations (e.g., for emergency reasons). Origin information must include the facility's full name and address, including state. Destination information must include the facility's full name and address, including state.
- Beginning and ending instrument readings (air) for the trip.
- If air transportation is necessary to bypass the Washington State ferry system, this must be clearly documented, including the reasons why the ferry would be inadequate in any particular case.

**Providers must make charts and records available to DSHS, its authorized contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

Documentation must show that clients are being triaged in a manner that ensures the most prompt access to appropriate care (i.e., to facilities with levels of care that are appropriate for the clients' injuries and/or medical care). Providers must consider the following:

- The availability of special regional resources such as:
  - ✓ Trauma centers;
  - ✓ Burn centers; and
  - ✓ Toxicology treatment centers;
- The presence of regional health care networks;
- The existence of physician to physician relationships; and
- The availability of care at the destination hospital.

## Quality of Care Audits and Reviews

(Refer to WAC 388-550-2541)

- MAA conducts prepayment and/or post payment reviews. Based on national and local medical policies, MAA selects providers demonstrating aberrant billing patterns for these reviews. MAA conducts these post payment reviews using the national and local policies effective when claims were processed. MAA requests refunds for any services that were not medically necessary based on these policies.
- To ensure quality of care, MAA may conduct an on-site review of any ambulance facility. See WAC 388-501-0130, Administrative Controls, for additional information on audits conducted by department staff.

## Reasons for Recoupment

Ambulance operators must comply with all MAA published rules and billing instructions. MAA will recoup reimbursements made to providers if, among other reasons, it finds providers to be out of compliance with MAA rules and billing instructions. Do not assume a paid claim is a covered benefit.



**Please Note:** MAA requires providers to document why an ambulance was the only appropriate and effective means of transportation without further endangering the client's health. Please ensure that proper documentation is included in the client's file.

## General Limitations to Payment for Ambulance Services

- Payment for ambulance services provided to an eligible client will be made on the basis of usual and customary charges or the rates established by MAA, whichever is lower. If there is a known third-party liable for payment, the provider must bill that party before billing MAA.
- MAA will not pay under fee-for-service for ambulance transportation services provided to a client enrolled in a department-contracted, prepaid health plan. Payment in such cases is the responsibility of the plan.
- Mileage for covered transports will be paid only from the client's point of origin to the point of destination.

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# Ground Ambulance

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## Levels of Transporting Service

MAA reimburses for two levels of medically necessary ground ambulance transportation: Basic Life Support (BLS) and Advanced Life Support (ALS).

- A **BLS** transport is one in which the client:
  - ✓ Requires and receives basic services en route, such as control of bleeding, splinting of fracture(s), treatment for shock, and cardiopulmonary resuscitation; or
  - ✓ Needs to be transported in a prone or supine position, with or without emergency services en route.
- An **ALS** transport is one in which the client requires and receives more complex services en route, such as:
  - ✓ Intravenous therapy;
  - ✓ Airway intubation;
  - ✓ Heart defibrillation by paramedics or other ALS-qualified personnel on-board a properly-equipped vehicle; or
  - ✓ Initiation of treatment for pneumothorax conditions.

## Ground Ambulance Coverage

MAA covers ground ambulance transport to and from medical services.



**Please Note:** In certain situations ambulance transport is included in bundled payments to hospitals or other providers. Payment for such inpatient transport is included in the hospital's Diagnosis Related Group (DRG) payment. In such a case the ambulance provider may not bill MAA or MAA's client for the transport. The hospital is responsible for the reimbursement of the ambulance transport.

- **Base Rate/Mileage**

- ✓ When a provider transports more than one client at a time to the same destination in the same ground ambulance, the provider must bill MAA:
  - At the additional client base rate (BLS or ALS) for the additional client;
  - No mileage charge for the additional client; and
  - Using a separate HCFA-1500 claim form for each client.
- ✓ The base rate billed for each transport must reflect the level of care and types of medical interventions by trained and certified personnel on-board. MAA classifies a ground ambulance transport as BLS even with paramedics or ALS-qualified personnel on board if no ALS-type interventions are provided en route. Medical necessity, **not the level of personnel on board an ambulance**, dictates which level (BLS or ALS) of ground ambulance service is billed to MAA.

**For example:** A client with an IV is transported from the hospital to a nursing facility. Hospital staff started and administered the IV. The ambulance personnel provided no other interventions except to monitor the client during the transport. This transport qualifies only for the BLS base rate.

- ✓ Providers may bill for ALS return pickup or second ALS transport (state-unique procedure code 0015A) only when all of the conditions for an ALS transport are met (e.g., when ambulance personnel **perform** ALS-level interventions). Otherwise, the BLS base rate (state-unique procedure code 0003A or 0004A) applies.
- ✓ When billing more than one trip for the same client on the same day, use one of the return trip state-unique procedure codes: 0003A, 0004A, 0015A, or 0016A. Use 0008A for return pickup mileage.

## Ground and Air Ambulance Medical Transportation

- ✓ MAA pays ground ambulance providers the same reimbursement rate per mile, regardless of the level of service.
- ✓ When billing for mileage, providers must bill MAA only for mileage calculated from the client's *point of pickup* to the *nearest appropriate point of destination*.

- **Oxygen, Medical Equipment, and Supplies**

- ✓ To bill more than one hour of oxygen (state-unique procedure code 0010A), include justifying documentation (e.g., transport from Spokane to Harborview) with the claim for review. One unit = one hour of oxygen. Enter units in box 24G and transport origin and destination in box 19 of the HCFA-1500 claim form.
- ✓ MAA reimburses providers only for oxygen and intravenous supplies and administration. Reimbursement will be the provider's usual and customary charge or MAA's maximum allowable fee -- whichever is less. All other equipment and supplies are included in the base rate. **The need for billed supplies must be clearly documented in the client's file.**
- ✓ When the hospital provides equipment, supplies, and staff, the ambulance provider may not bill for those services.

- **Waiting Time**

- ✓ MAA has established rates taking into consideration that transporting a client often involves some waiting time. This waiting time (state-unique procedure code 0011A) is not billable unless the waiting time is over 30 minutes and constitutes unusual circumstances. The claim must document the reason why the ambulance was required to wait and the exact amount of time involved.
- ✓ The provider must document waiting time in the client's file. Documentation must include the reason for the wait and actual length of time involved.
- ✓ **MAA does not reimburse for waiting time when the wait is related to a return pickup or second trip for the same client.**
- ✓ When waiting time is justified, procedure code **0011A** is reimbursed at a per-minute rate after the first 30 minutes. MAA will not reimburse for the first 1/2 hour (30 minutes) of waiting time.

**For example:** If the total waiting time is 60 minutes aggravated by a ferry delay, bill 0011A with the number of minutes of service minus the first 30 minutes (one minute = one unit). Bill a 90-minute wait as 60 units (90 - 30 = 60 minutes). Enter units in field 24G on the HCFA-1500 claim form.

- **“No Transport Calls”**

- ✓ MAA does not reimburse providers if no transport occurs and the client dies:
  - Before the ambulance arrives at the scene; or
  - After the ambulance arrives at the scene, but before medical intervention is provided.
- ✓ When an ambulance provider provides medical services to a client at the scene, but the client dies before transport is made, then the **appropriate BASE RATE** applies (state-unique code 0013A BLS or 0014A ALS). Commensurate with the level of service provided. Providers must document in their files what medical interventions were provided to the client by the ambulance crew at the scene before the client died.

- **Ferry Tolls**

- ✓ MAA reimburses for ferry tolls incurred when transporting MAA clients. The provider must provide proper documentation of tolls incurred [except for San Juan ferry tolls (state-unique procedure code 0018A, invoice required)].

- **Other Professional Services**

- ✓ MAA includes professional services performed by a registered nurse (RN) or a physician in the base rate reimbursement. ***MAA makes NO separate payment for professional services.***

- **Extra Attendant**

- ✓ In most situations, the base rate includes personnel charges. Therefore, an extra attendant is not paid separately. However, in the following situations, an additional payment for an extra attendant may be allowed when the need for those services is documented. Justification for an extra attendant would be:
  - Client violent or difficult to control;
  - More than one client requiring monitoring or medical attention being transported;
  - Client weighs 300 pounds or more; or
  - Transport of an Involuntary Treatment Act (ITA) patient requiring ambulance level services.

## Ground and Air Ambulance Medical Transportation

When billing MAA, the provider must send justification of the unusual circumstance that warranted the need for an extra attendant.

**For example:** A suspected heart attack client in most cases would not be viewed as unusual or require or warrant the need for an extra attendant. Although, if the suspected heart attack client was extremely obese or mentally disturbed, an extra attendant may be warranted provided documentation clearly indicates the **need** for such services.

## Modifiers

The following modifiers are single-digit modifiers used in combination. The first digit indicates the transport's place of origin. The destination is indicated by the second digit. You must enter these modifiers in field 24D on the HCFA-1500 claim form.

Providers must use a combination of **two digits** to identify origin and destination (e.g., 0002A NH, 0007A NH):



**Note:** Complete addresses for origin and destination must be kept in the client's file and available for review.

<b>D</b>	Diagnostic or therapeutic site other than "P" or "H" when used as origin codes
<b>E</b>	Residential, domiciliary, custodial facility
<b>G</b>	Hospital-based dialysis facility (hospital or hospital-related)
<b>H</b>	Hospital
<b>I</b>	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
<b>J</b>	Non-hospital based dialysis facility
<b>N</b>	Skilled nursing facility (SNF)
<b>P</b>	Physician's office (includes HMO non-hospital facility, clinic, etc.)
<b>R</b>	Residence
<b>S</b>	Scene of accident or acute event
<b>X</b>	(Destination code only) Intermediate stop at physician's office on the way to hospital

**Providers must bill all services associated with the same ambulance transport using the same two-digit modifier. Exception: state-unique procedure code 0013A and 0014A (deceased transport codes) do not require modifiers.**

# Fee Schedule

**Modifiers required on all codes except 0013A and 0014A.  
See *Modifiers*, page D.5 for descriptions.**

State-Unique Procedure Code	Description	Maximum Allowable Fee
<b><u>Basic Life Support</u></b>		
0002A	Basic Life Support (BLS), base rate, one way, one client. <b>Modifier Required.</b>	\$95.31
0004A	Basic Life Support (BLS) return pick-up or second BLS transport, same client, same 24-hour period (rate includes waiting time). <b>Modifier Required.</b>	\$95.31
0003A	Basic Life Support (BLS), third transport, same client, same 24-hour period, justification required. <b>Modifier Required.</b>	\$95.31
0013A	Basic Life Support (BLS) services provided on scene, client dies before transport. Includes supplies used at scene, no mileage allowance.	\$95.31
<b><u>Advanced Life Support</u></b>		
0001A	Advanced Life Support (ALS), base rate, emergency transport, one way, one client. <b>Modifier Required.</b>	\$137.40
0015A	Advanced Life Support (ALS) return pickup or second ALS transport, same client, same 24-hour period (rate includes waiting time). <b>Modifier Required.</b>	\$137.40
0014A	Advanced Life Support (ALS) services provided on scene, client dies before transport. Includes supplies used at scene, no mileage allowance.	\$137.40

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State-Unique Procedure Code	Description	Maximum Allowable Fee
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**Additional Client Base Rate**

0005A	Emergency transport, base rate, each additional client, one way. <b>Modifier Required.</b>	\$42.63
0006A	Emergency transport, base rate, return pickup or second transport, each additional client. <b>Modifier Required.</b>	\$42.63

**Mileage**

0007A	Loaded mileage, one way, first passenger only, first trip. <b>Modifier Required.</b>	\$2.81/mile
0008A	Loaded mileage, return pick-up or second trip same 24-hour period, one way, first passenger only. <b>Modifier Required.</b>	\$2.81/mile
0016A <b>NEW!</b>	Loaded mileage, third transport, same client, same 24-hour period, justification required. <b>Modifier Required.</b>	\$2.81/mile

**Disposable Supplies**

0010A	Oxygen supplies/administration, life-sustaining situation, per trip (all-inclusive fee; includes mask or cannula, and one hour of oxygen). <b>Modifier Required.</b> One unit = one hour of oxygen. Justification required more than one hour. See page D.3.	\$17.28
0044A	IV supplies/administration (all-inclusive fee). <b>Modifier Required.</b>	\$7.45

**Ferry Tolls**

0009A	Puget Sound ferry tolls, one way (inclusive of vehicle, driver, and passenger(s)). <b>Modifier Required.</b>	\$13.00
0018A <b>NEW!</b>	San Juan Island ferry tolls, one way (inclusive of	By Report

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State-Unique Procedure Code	Description	Maximum Allowable Fee
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vehicle, driver, and passenger(s)). **Modifier Required. Invoice Required.**

**Other Services**

0011A	Waiting time (justification required), loaded, allowed after first 30 minutes. <b>Modifier Required.</b>	\$.63/min
0012A	Extra certified/licensed attendant, justification required.* <b>Modifier Required.</b>	\$23.18
0020A	Defibrillation, BLS trips only (included in ALS trips). <b>Modifier Required.</b>	\$31.74

\*Justification for Extra Attendant:

- When the client is violent or difficult to control;
- When there is more than one client requiring monitoring or medical attention being transported;
- Client weighs 300 lbs. or more; or
- Transport of ITA patient.



# Air Ambulance

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## What is covered?

- MAA covers air ambulance transportation services, by either a helicopter or a fixed wing aircraft, when:
  - ✓ The vehicle and crew meet MAA's guidelines and requirements;
  - ✓ The destination is an acute care hospital; and
  - ✓ The client's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance, and:
    - The point of pickup is inaccessible by ground ambulance vehicle; or
    - Great distances and/or obstacles are involved in getting the client to the nearest hospital with appropriate facilities.

The client's condition must be such that the time needed to transport by ground or the risk of transportation by ground poses a threat to survival or could seriously endanger the client's health.

- If the client is transported by air ambulance, but MAA determines that ground ambulance would have sufficed, MAA bases payment on the amount payable for ground transport, if less costly. Also, as with ground ambulance, if the transport was medically necessary, but the client could have been treated at a nearer hospital, the air transport payment is limited to the rate from the point of pickup to that nearer hospital.
- MAA covers air ambulance transport for transfer of a client from one hospital to another when medically appropriate (e.g., transportation by ground ambulance would endanger the client's health). In these cases, the transferring hospital does not have adequate facilities to provide the medical services needed by the client.
- Air ambulance operators may only bill MAA for air mileage calculated from the client's point of pickup to the nearest appropriate point of destination. The air ambulance operator must pay subsequent ground ambulance transportation (beyond air mileage) to the ground ambulance operator. MAA reimburses a lift-off fee for each client.
- If multiple transports are made in the same day, every lift-off is a separate trip. Records must reflect why multiple trips have occurred on the same day.

## **Vendor Requirements**

Air ambulance operators must:

- Be a participating Medicaid provider in at least one of the 50 states;
- Have signed a Washington State MAA core provider agreement; and
- Agree to accept MAA rates as payment in full.

## **Air Ambulance Services to Out-of-State Treatment**

- MAA allows out-of-state transportation only when medical services have been prior approved by MAA as an exception to rule. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the out-of-state treatment to:

Division of Health Services Quality Support  
Quality Review Services Section  
(360) 725-1555 (phone)  
(360) 586-1471 (fax)

- MAA staff considers the following criteria when reviewing a request for out-of-state services:
  - ✓ There is no equally effective, less costly alternative available in Washington State; and
  - ✓ The service/treatment is not experimental.
- After authorization is received from MAA for the out-of-state treatment, call the Professional Reimbursement Section at 360-725-1835 to arrange for air ambulance transport.
- Air ambulance transports in these cases are reimbursed at negotiated rates. MAA payment is payment in full.

## Air Ambulance Services from Out-of-State Treatment to In-State Treatment

- MAA considers transfers from out-of-state facilities on a case-by-case basis. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the in-state treatment to:

Division of Health Services Quality Support  
Quality Review Services Section  
(360) 725-1555 (phone)  
(360) 586-1471 (fax)

After authorization is received from MAA for the in-state treatment, call the Professional Reimbursement Section at 360-725-1835 to arrange for air ambulance transport.

- MAA uses commercial airline companies whenever the client's medical condition allows.



**Please Note:** MAA holds air ambulance providers to the contractually agreed upon rate for each medically necessary, interstate air ambulance trip MAA prior authorizes. Therefore, providers should maintain close contact with the discharging and/or receiving facilities to ensure proper coordination of the client transfer process.



**Example:** When flying to another state to pick up a client, an air ambulance provider should maintain contact with the facility providing medical services to the client in case the client has a setback and is unfit for transport. This will help ensure that the provider does not reach the facility only to have to leave without the client and return later for pickup, thus being reimbursed for only one trip when two were made.

# Fee Schedule

MAA assumes that all air transports are ALS, which is taken into consideration in the rates. There is no separate reimbursement for equipment and supplies such as incubators, dressings, or oxygen tanks. The base rate includes these costs.

State-Unique Procedure Code	Description	Maximum Allowable Fee
0503A	Fixed wing lift-off, per client transported.	\$473.63
0504A	Rotary lift-off, per client transported.	\$447.28
0510A	Fixed-wing mileage, one way, per flight, equally divided by the number of clients transported.	\$5.50/ air mile
0511A	Rotary mileage, one way, per flight, equally divided by the number of clients transported.	\$13.31/ air mile



**Note:** MAA conducts post-pay reviews. Based on information available at the time of service, MAA may determine that ground ambulance transport would have been sufficient. If this happens, MAA pays the rate for ALS ground service, if less costly.

**The need for air ambulance transport must be clearly documented in the ambulance provider's records.**

# General Billing

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## What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.
- 
- MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:
  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that affects the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed<sup>2</sup> certification criteria.



**Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ✓ DSHS certification of a client for a retroactive<sup>3</sup> period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

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**2 Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

**3 Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

## Ground and Air Ambulance Medical Transportation

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.
- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



**Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

## What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

## How do I bill for mileage?

- Bill mileage only from the client's point of pickup to the point of destination.
- If an air ambulance transports more than one client on a single trip, MAA will pay the lift-off rate for each client. If more than one client is served with a single transport, document each pick-up point, destination, number of air miles. The miles associated with the trip must be divided equally by the number of clients transported.
- For ground ambulance only, if the provider makes a second or third transport for the same client during the same 24-hour period, then use a second or third mileage code.

## How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

### Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

**When billing Medicare:**

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the MAID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.



**Note:** Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.



**Note:** A Medicare Remittance Notice or EOMB must be attached to each claim.

## **Medicare Part B**

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the “XO” indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.



**Note:** Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.



**Note:** A Medicare Remittance Notice or EOMB must be attached to each claim.

### **Payment Methodology – Part B**

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MAA uses Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider accepts assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

## **Third-Party Liability**

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 1-800-562-6136.

# How to Complete the HCFA-1500 Claim Form

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The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

## General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

## FIELD DESCRIPTION

**1a. Insured's I.D. No.:** Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical Assistance IDentification (MAID) card. This information consists of the client's:

- a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- d) An alpha or numeric character (tiebreaker).

*For example:*

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

**NOTE:** The MAID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a **B** in *field 19* to indicate the baby is on a parent's PIC.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

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3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client.
4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)
9. **Other Insured's Name:** Secondary insurance. When applicable, show the last name, first name, and middle initial of the insured. If the client has insurance that is secondary to the insurance listed in *field 11*, enter it here.
- 9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
- 9b. Enter the other insured's date of birth.
- 9c. Enter the other insured's employer's name or school name.

- 9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) NUMBER:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.
- 11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

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**11c. Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (*Note: This may or may not be associated with a group plan.*)

**11d. Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If *yes*, you should have completed *fields 9a.- d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If *11d.* is left blank, your claim may be processed in error.

**19. Reserved For Local Use:** When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*.

**Medicare/Medicaid Eligible Clients:** Also when applicable, enter *nonemergent* here when you are billing for a nonemergency service provided to a client whose physical condition was such that the use of any other transportation method was inadvisable.

**21. Diagnosis or Nature of Illness or Injury:** When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

**22. Medicaid Resubmission:** When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim*

*number* listed on the Remittance and Status Report.)

**24. Enter only one (1) detail line per claim line (fields 24A - 24K). If you bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

**24A. Date(S) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 2000 = 070400).

**24B. Place of Service:** Required. Enter code **9**, *Other*.

**24C. Type of Service:** Required. Enter a **9** for all services billed.

**24D. Procedures, Services or Supplies HCPCS/Modifier:** Required. Enter the appropriate procedure code for the services being billed.

**24E. Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code or V90.0. When code V90.0 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*).

**24F. \$ Charges:** Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. **Do not** include dollar signs or decimals in this field.

**24G. Days or Units:** Required. Enter the total number of mileage or service units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number:** Leave this field blank.
26. **Your Patient's Account No.:** This is any nine-digit alphanumeric entry *that you may use as your internal reference number.* You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.
28. **Total Charge:** Required. Enter the sum of your charges. **Do not** use dollar signs or decimals in this field.
29. **Amount Paid:** If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. **Do not** use dollar signs or decimals in this field or put Medicare payment here.
30. **Balance Due:** Required. Enter balance due. Enter total charges **minus** any amount(s) in *field 29*. **Do not** use dollar signs or decimals in this field.
33. **Billing Name, Address, Zip Code, and Telephone #:** Required. Enter the provider's *Name, Address,* and *Telephone #* on all claim forms.
- Group:** Enter your seven-digit provider number as assigned to you by MAA.

## Ground and Air Ambulance Medical Transportation

## Sample Ground Ambulance HCFA-1500 Claim Form

**Sample Air Ambulance HCFA-1500 Claim Form**

# How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

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The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

**The HCFA-1500 claim form, used for Medicare/Medicaid Benefits  
Coordination, cannot be billed electronically.**

## General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

### **FIELD DESCRIPTION**

**1a. Insured's I.D. No.:** Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information consists of the client's:

- a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).

- c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- d) An alpha or numeric character (tiebreaker).

*For example:*

1. Mary C. Johnson's PIC looks like this: C010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

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**NOTE:** The MAID card is your proof of eligibility.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).
3. **Patient's Birthdate:** Required. Enter the birthdate of the MAA client. **Sex:** Check **M** (male) or **F** (female).
4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.
5. **Patient's Address:** Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).
9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
- 9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

- 9b. Enter the other insured's date of birth.
- 9c. Enter the other insured's employer's name or school name.
- 9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.
- 11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

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| <p><b>11b. <u>Employer's Name or School Name:</u></b> Primary insurance. When applicable, enter the insured's employer's name or school name.</p> <p><b>11c. <u>Insurance Plan Name or Program Name:</u></b> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>)</p> <p><b>11d. <u>Is There Another Health Benefit Plan?:</u></b> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d.</i> If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. <b>If 11d. is left blank, the claim may be processed and denied in error.</b></p> <p><b>19. <u>Reserved For Local Use - Required. When Medicare allows services, enter XO to indicate this is a crossover claim.</u></b></p> <p><b>22. <u>Medicaid Resubmission:</u></b> When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).</p> | <p><b>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K).</u></b> <b><u>If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</u></b></p> <p><b>24A. <u>Date(S) of Service:</u></b> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2000 = 070400).</p> <p><b>24B. <u>Place of Service:</u></b> Ground and Air Transport - "9". Required.</p> <p><b>24C. <u>Type of Service:</u></b> Required. Enter 9.</p> <p><b>24D. <u>Procedures, Services or Supplies HCPCS/Modifier:</u></b> Required. <b><u>Coinurance and Deductible:</u></b> Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.</p> <p><b>24E. <u>Diagnosis Code:</u></b> Required. Enter the ICD-9-CM diagnosis code or V90.0. When code V90.0 is used, written justification noting condition requiring level of service is necessary (enter in <i>field 21</i>).</p> <p><b>24F. <u>\$ Charges:</u></b> Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.</p> <p><b>24G. <u>Days or Units:</u></b> Units: Required. Multiple units valid only on Mileage and Waiting Time codes. For all other codes enter a "1".</p> |
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- 24K. **Reserved for Local Use:** Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).
26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.
27. **Accept Assignment:** *Required.* Check yes.
28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.
29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**
30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**
32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**
33. **Billing Name, Address, Zip Code, and Telephone #:** Required. Enter the provider's *Name, Address,* and *Telephone #* on all claim forms.
- Group:** Enter your seven-digit provider number as assigned to you by MAA.

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**Sample Ground Ambulance Medicare Part B/Medicaid Crossover  
HCFA-1500 Claim Form**

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**Sample Air Ambulance Medicare Part B/Medicaid Crossover  
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